STATE OF MISSISSIPPI

COUNTY OF HARRISON

PERSONALLY APPEARED BEFORE ME, THE UNDERSIGNED AUTHORITY IN AND FOR THE JURISDICTION AFORESAID, MIKE ERNST, WHO, AFTER BEING BY ME, FIRST DULY SWORN, DEPOSES AND SAID; THAT ON HIS OWN PERSONAL KNOWLEDGE HERETO ATTACHED AND ANNEXED IN THE SUM OF **($19,627.06) NINETEEN THOUSAND SIX HUNDRED TWENTY SEVEN DOLLARS AND SIX CENTS** IS TRUE, ACCURATE AND CORRECT, AND JUSTLY DUE AND OWING.

FROM: LIONELL MCCLELLAND
ACCOUNT NUMBER: 916100792
TO: MEMORIAL HOSPITAL AT GULFPORT

AND THAT NO PART THEREOF HAS BEEN PAID, EXCEPT, AS NOTED ON SAID STATEMENT, AND SAID ACCOUNT IS SUBJECT TO NO COUNTERCLAIMS OR SET-OFFS.

I, OR WE, HEREBY AUTHORIZE SOUTHERN FINANCIAL SYSTEMS, TO TAKE LEGAL ACTION ON BEHALF OF MEMORIAL HOSPITAL AT GULFPORT AGAINST THE ABOVE NAMED DEBTOR FOR THE AMOUNT OF THE CLAIM STATED ABOVE PLUS COST. THIS SAME CLAIM MENTIONED WAS ALSO PREVIOUSLY ASSIGNED TO SOUTHERN FINANCIAL SYSTEMS FOR COLLECTION: AND THEY ACT AS OUR AGENT IN THIS MATTER.

MIKE ERNST

SWORN TO AND SUBSCRIBED BEFORE ME THIS 6 DAY OF August, 2010.

NOTARY PUBLIC

MY COMMISSION EXPIRES MISSISSIPPI STATEWIDE NOTARY PUBLIC MY COMMISSION EXPIRES NOV. 15, 2010

EXHIBIT "A"

RELEASE OF MEDICAL INFORMATION

I give my permission to Memorial Hospital at Gulfport to release medical information needed to process any claim related to my treatment to any of my insurance companies, including automobile or other liability insurance companies. Memorial Hospital at Gulfport can release this medical information only to the insurance company or any third party payor involved in this claim. Third party payors may be Medicare, Medicaid, CHAMPUS, CHAMPVA, automobile or other liability insurance, or any workers' compensation plan. This permission is good for the time provided in Memorial Hospital at Gulfport's Health Information Management Department Policy, unless I deliver a written notice of cancellation to the Health Information Management Department at Memorial Hospital at Gulfport, 4500 13th Street, Gulfport, MS 39501.

ASSIGNMENT OF BENEFITS

I authorize, request and assign payment directly to Memorial Hospital at Gulfport covering this period of treatment, and past and future treatment if related to the incident or condition giving rise to this treatment or admission, by all insurance carriers or other payors with whom I have coverage or from whom benefits are, or may become, payable to me, including settlements or judgments flowing from the incident for which I am receiving treatment. This authorization shall include all benefits specified and/or master medical benefits otherwise payable to me, but shall not exceed the charges for this and any other period of treatment. I have given current and correct information about my insurance or other benefit status to Memorial Hospital at Gulfport. Notwithstanding this Assignment of Benefits, if my insurance and/or benefit programs, including but not limited to an insured or self-insured ERISA Plan, do not pay all charges in connection with my treatment, I understand and agree to be responsible for paying the balance of the charges, regardless of the reason why my insurance and/or benefit programs failed or refused to pay all charges.

FINANCIAL AGREEMENT AND GUARANTY OF PAYMENT

In consideration of services rendered the above named patient, I unconditionally guarantee that all charges connected with treatment rendered to the above patient which are not paid by an insurance or a benefit program, including but not limited to an insured or self-insured ERISA Plan, will be paid in full within sixty (60) days of final billing, regardless of the reason why such insurance or benefit program failed or refused to pay. If I do not remit full payment within that time, Memorial Hospital at Gulfport may refer the bill to an attorney or collection agency. If the bill is so referred, I understand that I will responsible for attorneys' fees up to 33 1/3 % in addition to the amount of the bill and legal interest from 60 days after final billing. I understand that Memorial Hospital at Gulfport has the right to examine credit bureau files for financial information on unpaid debts. Memorial Hospital at Gulfport may inform any credit bureau of any bill for care not paid within sixty (60) days of final billing.

If any clause, provision or section of this Consent for Treatment and Services shall be ruled invalid or unenforceable by any arbitrator or court of competent jurisdiction, the invalidity of such clause, provision or section shall not affect any of the remaining clauses, provisions or sections of this document, which shall be valid and enforceable to the fullest extent permitted by law.

I have read and understand this Consent for Treatment and Services and agree to be bound by all its terms and provisions. I had a chance to ask questions about any portion of this document prior to signing. Any questions I had were answered to my satisfaction.

Patient or Person Legally Permitted to Sign	06/10/2009 Date	Witness Signature	06/10/2009 Date

If other than patient, print name and relationship.

Name of Person Legally Permitted to Sign _____ Relationship to Patient _____

IF THE PATIENT IS UNABLE TO CONSENT TO THE FOREGOING OR IS A MINOR, COMPLETE THE FOLLOWING:

THE PATIENT IS A MINOR (_____ YEARS OF AGE) OR THE PATIENT IS UNABLE TO CONSENT BECAUSE _____

Rev 1/2009

MCCLELLAND, LIONELL
PHYSICIAN, E R
MR# 0000429883
Acct#:0916100792
06/10/2009 [redacted]
ERM M 27